D. Definition of Services: Case management for developmentally disabled individuals.

Purpose Case management is a system intended to assist eligible individuals in gaining access to needed medical, social, educational, and other services. In order to assist the individual comprehensively, the responsibility for locating, coordinating, and monitoring those services which are needed by each individual is placed with a designated person or organization.

Case management activities include:

1. Assessment of the individual's need for medical, social, educational, and otherservices.

   a. Initially determining and documenting an applicant's need for individualized, specialized services for a developmental disability, including case management. Also, informing and otherwise assisting the applicant or othersresponsible for the applicant during the assessment process.

   b. Completion of the Health Risk Screening Tool (HRST). The HRST process will be initiated with full implementation of waiver individuals and may be initiated for non-waiver individuals with qualifying DD Health Home qualifications. The HRST process must be conducted as a component of the annual Individual Support Plan (ISP) process for waiver individuals and may be completed for non-waiver individuals, and may be updated throughout the ISP plan year when changes in the individual's status are identified. The HRST will assist with the identification of additional supports and services the development of any applicable Health Risk Support Plans as a component of the ISP.

   c. Obtaining necessary releases, collecting records, preparing ecological andbehavioral assessments, arranging other assessments as needed, and coordinating the overall assessment process to identify the comprehensive array of services and supports needed.

   d. Facilitating individual service plan (ISP) development and on-going review asa member of the interdisciplinary team. Interpreting the comprehensive. assessment and ISP outcomes to the individual and/or responsible others.

   e. Re-assessments are completed annually at a minimum or more frequently ifthe individual's needs change.

2. Planning for services.

   a. From the ISP, developing and writing an individualized service plan which will enable the prioritized outcomes of the ISP to be attained.

   b. At a minimum, annually reviewing the individualized service plan to ensure itcontinues to be appropriate to the needs of the individual and effective in achieving the prioritized outcomes of the ISP.

   c. When needed, as indicated by the client's response to the prioritized outcomes, redesigning the service plan to further promote individualizedtraining and growth or to incorporate new outcomes.